6/2/10 POC accepted - B. Cavaney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN528S	A. BUILDING _____ B. WING _____	04/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES	3101 PLUMAS RENO, NV 89509

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Z 000	Initial Comments This Statement of Deficiencies was generated as a result of a State licensure survey conducted at your facility on April 5, 2010 through April 12, 2010, in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing. The State licensure survey was conducted concurrently with the annual Medicare recertification survey. The census was 162 residents. The sample size was 24 residents, which included three closed records. There were four unsampled residents. A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigations by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	Z 000	 The Statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with Federal and State regulations, the facility has taken or will take actions set forth in the following plan of correction. The following plan of correction constitutes Manor Care Health Services allegations of compliance. The alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
Z230 SS=G	NAC 449.74469 Standards of Care A facility for skilled nursing shall provide to each patient in the facility the services and treatment that are necessary to attain and maintain the	Z230		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 5-17-10

Bureau of Health Care Quality and Compliance

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Z230	Continued From page 1 patient's highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment conducted pursuant to NAC 449.74433 and the plan of care developed pursuant to NAC 449.74439. This Regulation is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide the necessary services and care to attain the highest level of well being by not providing relief from pain for 2 of 24 residents (Resident #3 and #21). Findings include: Resident #3 Resident #3 was admitted to the facility originally on 1/27/10, with a re-admission on 3/4/10. Diagnoses included spinal stenosis, chronic pain, reflux and hypertension. On 4/5/10 at approximately 11:25 AM, it was observed that Resident #3 approached a medication nurse on the Kensington Unit, asking if she was his nurse. The resident proceeded to tell the nurse that he was in pain and that his medication was due five minutes ago. The medication nurse was overheard by this surveyor to tell Resident #3 that she had already told him that he had received his pain medication, and that additional medication was not due until 1:00 PM and that she would give it to him at that time. There was no attempt, on the part of the nurse, to evaluate the existing pain and/or the cause of the pain. The nurse did not employ any non-pharmacological interventions that might have improved Resident #3's physical or	Z230	**Z 230** Facility does and will continue to provide each resident the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** Resident #3 is no longer at the facility. Resident #21 medications are being given as ordered. ***How the facility will identify others having the potential to be affected:*** Patients with the potential to be affected are new admissions and those that have not reached their pain management goal. ***What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur:*** Re-educate licensed nursing staff to pain management guidelines. Re-educate licensed staff to process to follow when a pain medication is unavailable. Patients with pain that is not managed will be tracked on a daily basis by the nurse managers and reported at the daily IDT meeting for evaluation. Patient's pain management program will be revised in cooperation with the physician and care plans updated. Monitoring will continue until the patient's pain goal is met.	

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Z230	Continued From page 2 psychological well being, such as positioning, or to offer other physical modalities (such as ice packs or the application of heat). There was no attempt by the nurse to address the barriers that prevented the resident from receiving adequate medication to manage the resident's perceived pain. Review of Resident #3's record revealed that the physician on 3/4/10 ordered pain assessments to be done daily with a 1-10 scale being utilized. Also ordered was a pain medication, Oxycodone 5 milligrams (mg) every 8 hours as needed for pain. An additional pain medication, Ultram 50 mg, was ordered to be given twice-a-day (at 8:00 AM and 8:00 PM). Review of the Medication Administration Record (MAR) disclosed that Resident #3 received the Ultram at 8:00 AM that morning, but had not received the Oxycodone since midnight. The pain evaluation documentation indicated that the resident had not experienced any pain on 4/5/10. The nurses notes did not document the incidence or mention the resident having episodes of pain. Review of the resident's care plan addressing pain revealed two approaches: Administering pain medication as ordered and noting its effectiveness; and Evaluation of pain characteristics, intensity, location, precipitating factors/relieving factors. Note: The care plan approaches did not outline the use of non-pharmacological interventions. On 4/6/10, when the Medication Nurse was interviewed about the incident, the nurse indicated that she was awaiting the Ultram to take effect (medication which had been given 3 1/2 hours earlier). She was unable to explain why	Z230	***How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:*** DON/designee will monitor patient outcomes through validation at the IDT meeting, review of the pain tracking forms, and random checks of the patient medication administration record. DON/designee will report results of monitoring to the Administrator and QA committee on an ongoing basis. EXHIBIT VIII & IV QA committee will be responsible for monitoring compliance. Administrator heads the QA committee and is ultimately responsible. Corrective action will be complete by May 26, 2010.	

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Z230	Continued From page 3 she had selected 1:00 PM as the time to give the as-needed medication, Oxycodone. Note: The Oxycodone could have been given anytime after midnight or after waiting several hours after administering the Ultram. Resident # 21 Resident #21 was admitted to the facility on 1/22/10, following an acute care hospitalization. His primary diagnoses included left-sided hemiplegia following a stroke. Resident #21 also had a gastrostomy tube for nutrition and medication administration. Upon arrival to the facility, Resident #21 required a communication board due to unclear speech and deterioration in communication. A random observation on 4/12/10, revealed the Licensed Practical Nurse (LPN) asked Resident #21 if he required something, and brought the communication board to the Resident. Resident #21 pointed to the picture of "pain." The LPN acknowledged Resident #21 was scheduled to get his pain medicine at this time. The clinical record revealed that upon admission, Resident #21 was prescribed: Acetaminophen 325 milligrams (mg), two tablets every six hours as needed for pain; and Percocet 5/325 mg, two tablets every six hours as needed for severe pain. Resident #21's pain medication order was changed on 2/10/10, to the Percocet now being prescribed to be one tablet every four hours for pain as needed, and two tablets every four hours as needed for severe pain.	Z230		

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Z230	Continued From page 4 On 2/18/10, this pain prescription was increased again, related to the frequent need for pain medication administration. The new order increased the strength of Percocet to 10/325 mg, and now prescribed to be given every four hours routinely. Review of the clinical record also revealed the original order of Acetaminophen (1/22/10) remained active. Review of the clinical record revealed that from 4:00 AM on 3/6/10 to 4:00 PM on 3/7/10, approximately 45 hours, Resident #21 did not receive the prescribed Percocet. Documentation on the back of the medication administration record (MAR) indicated the pain medicine was not available because it had not been received from the pharmacy. On 4/4/10 from 8:00 PM through 4:00 PM on 4/5/10, the MAR indicated Resident #21 did not receive the prescribed Percocet, because it was not available. Resident #21 was without pain medication for 20 hours. Documentation in the clinical record revealed the nursing staff documented the medication was not available from pharmacy. There was no documentation in the clinical record that the physician was notified for a possible alternative medication, that Resident #21 was specifically evaluated regarding his pain levels, or was he medicated with the Acetaminophen as a interim pain control option until the Percocet was available. In an interview with an LPN on 4/9/10, the LPN explained that the controlled medications like Percocet now needed monthly forms signed by the physician, before pharmacies can refill the prescription. However, the LPN indicated that she would have either called the physician for interim pain medication orders that did not require	Z230		

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Z230	Continued From page 5 special documentation, or administered the Acetaminophen that was ordered. The LPN acknowledged that the physician should have been contacted. Severity: 3 Scope: 1	Z230	**Z 291**	
Z291 SS=G	NAC449.74487 Nutritional Health; Hydration 2. A facility for skilled nursing shall provide each patient in the facility with sufficient fluids to maintain proper hydration and health. . This Regulation is not met as evidenced by: Based on observation, record review, policy review, and interview, the facility failed to ensure that 1 of 24 residents (Resident #14) was provided with sufficient fluid intake to maintain proper hydration. Findings include: Resident #14 was initially admitted to the facility on 2/16/10, with readmission on 3/28/10. Diagnoses included Parkinson's disease, diabetes Type II, hypertension, hypothyroidism, gastroesophageal reflux disease, gout, and urinary tract infection (UTI). A review of Resident #14's admission Minimum Data Set (MDS), dated 2/23/10, revealed that the resident had modified independence with daily decision-making (some difficulty in new situations only) and that he required some assistance with eating. Record review revealed that the resident was his own responsible party. Prior to admission to the facility on 2/16/10, Resident #14 was admitted to the hospital on 2/12/10, with a UTI, for which he was given	Z291	Facility does and will continue to provide each resident with sufficient fluid intake to maintain proper hydration and health. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** Resident #14 is no longer at the facility. ***How the facility will identify others having the potential to be affected:*** Patients that have been clinically identified as having symptoms of volume depletion and patients who through the RAI process have been identified as being at risk for hydration issues have the potential to be affected and will be reviewed. ***What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur:*** In-service of licensed nursing staff, C.N.A.s, and Registered Dieticians on recognition of early symptoms of insufficient fluid intake and strategies for providing adequate hydration. Ensure accurate assessment of hydration utilizing the dehydration RAP assessment. Develop a comprehensive care plan to meet the individual hydration needs of the patient.	

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Z291	Continued From page 6 antibiotics. Upon discharge from the hospital on 2/16/10, the resident's blood urea nitrogen (BUN) level was 38. (The normal reference range for BUN between 6 and 20, and a high BUN can be an indicator for dehydration.) Note: Discharge diagnoses from the hospital did not include dehydration. Upon admission to the facility on 2/16/10, the resident was placed on a "cardiac ADA" diet with thin liquids. A Nutrition Risk Assessment was completed by one of the facility's dietitians on 2/24/10. The assessment indicated that Resident #14's total daily calorie and fluid needs were 2100 calories (kcals) and 2150 -2500 cubic centimeters (cc) respectively. The dietitian noted: "Average po (by mouth) intake 70% of meals, approximately 1600 kcals consumed. 76% of kcal needs met. Large portions may be appropriate to meet calorie needs. Declined snacks, just wants larger portions. No labs available to assess." The assessment did not include any reference to the resident's fluid consumption. The admission MDS triggered nine Resident Assessment Protocol (RAP) problem areas for Resident #14, including: Cognitive loss, Rehabilitation Potential, Urinary Incontinence, Psychosocial Well-Being, Falls, Nutritional Status, Dehydration, Pressure Ulcers, and Psychotropic Drug Use. The record indicated that these triggered areas were assessed, with the determination that care plans were to be developed for all areas except for Cognitive Loss. A note by the social worker, dated 2/25/10, on the Cognitive Loss RAP assessment, read, "Patient has Parkinson's disease and he has some difficulties in new situations; however, he is able to speak and advocate for himself, so this has not caused him any problems to date."	Z291	In-service of licensed nursing staff on process for timely follow-up to abnormal lab results. Nurse Manager will review lab results and identify if further action is needed. Nurse Manager will bring abnormal lab results to daily IDT meeting to communicate outcomes. In-service of Social Service staff on documentation and care planning of discussions with family regarding treatment choices. ***How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:*** DON/designee and Registered Dieticians will monitor the hydration process through meal observation, IDT meeting attendance, and review of labs, RAPs, care plans and outcomes. Monitoring results will be given to the Administrator and QA committee on an ongoing basis. Exhibit III QA committee will be responsible for monitoring compliance. Administrator heads the QA committee and is ultimately responsible. Corrective action will be complete by May 26, 2010.	

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Z291	Continued From page 7 According to the MDS Coordinator, interviewed on 4/9/10, at 11:00 AM, the expectation was that a care plan would be developed, unless there was a "No" answer to the question on each RAP assessment, "Will (this RAP) be addressed in the care plan?" and unless there was a documented rationale for this decision. On the Dehydration RAP assessment, there was a "yes" marked after question about whether Dehydration would be addressed in a care plan. A follow-up question on the Dehydration RAP assessment was, "If care planning for this problem, what is the overall objective?" The written answer was "Minimize risks," with the risk factors of presence of infection and frequent laxative use checked off on the form. Record review revealed that a care plan for Resident #14 had never been developed, and this was confirmed by the MDS Coordinator. Record review revealed that a care plan for Nutritional Status had been developed for Resident #14, and included the following interventions: "Monitor skin, labs, and hydration." A review of meal intake information for the resident revealed that meal intake percentages were being inputted into an electronic system by Certified Nursing Assistants (CNAs), but fluid consumption was not included because the system did not allow for a method to document fluid intake. The facility's two dietitians were interviewed on 4/9/10, at 10:30 AM. When interviewed about the facility's new electronic tracking system, they confirmed that CNAs were unable to record fluid intake amounts on the system. When interviewed how they determined if a resident was	Z291		

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Z291	Continued From page 8 dehydrated, the dietitians communicated that they relied on reviewing nursing skin checks, labs, and interviewing CNAs responsible for assisting the resident in the dining room. The dietitians acknowledged that the previous method of having CNAs document meal and fluid intake in a binder after each meal provided, "...more complete, accurate" information, whereby cubic centimeters (cc's) of fluids could be tracked and monitored. A review of Interdisciplinary Progress Notes for Resident #14's revealed that starting 3/8/10, the resident was becoming more lethargic, more disoriented, more prone to falls, and was having more difficulty swallowing. On 3/19/10, both the resident's physician and family were notified of the change of condition. The physician ordered blood tests and noted the following: "Family wishes pt (patient) to be monitored here. If needs fluids, will need IV." The laboratory results from 3/19/10, for Resident #14 showed that the BUN was 58. According to the Progress Notes on 3/20/10, the speech therapist assisted the resident with thickened liquids at lunch and recommended that the diet order be changed to thickened liquids, mechanical soft. On 3/23/10, the resident's physician wrote, "Cont. to encourage eating; draw labs stat (immediately) to R/O (rule out) dehydration." The BUN from that draw on 3/23/10 was 61. The physician documented on 3/24/10, "...dehydrated, elevated BUN, give IV fluids per BMP (Basic Metabolic Panel)." On 3/24/10, at 7:00 PM, Resident #14 started on IV fluids. Another BMP was collected on 3/25/10 at 4:45 PM, and the BUN was 55. In an interview with the Kensington unit nurse	Z291		

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Z291	Continued From page 9 manager on 4/9/10, at 9:00 AM, Resident #14's swallowing ability worsened on 3/19/10, and on 3/26/10 the speech therapist recommended "NPO" (nothing by mouth), and the resident's family did not want the facility to initiate tube feeding. On 3/26/10 2:45 PM, the resident was taken to the hospital, where the Admission diagnoses included Dehydration, and he returned to the facility on 3/28/10 with an improved BUN of 36. As of 4/9/10, the nurse related that the resident had not been placed on Comfort Care measures or Hospice. According to the facility's undated, "Hydration Management Guideline," the assessment process for hydration was to include the following: completing the MDS, completing triggered RAPs, initiating a new care plan or updating a current care plan, implementing care plan interventions, providing ongoing risk reducing interventions, obtaining urine specific gravity as clinically indicated, initiate peripheral IV as clinically indicated, and initiate and monitor center specific systems: hydration cart, hydration symbol, and water pass. There was no evidence of a Dehydration care plan in Resident #14's record, nor was there evidence that there was a system in place to monitor residents at risk for dehydration, through such measures as documenting daily fluid intake or obtaining urine specific gravity. IV fluids were not initiated until 3/24/10, five days after it was discovered that the resident's BUN level was at 58. Severity: 3 Scope: 1	Z291		